

Deaconess Hospital

1992 ANNUAL REPORT

**Working to meet the
health-care challenge
through partnerships and
strategic alliances with
others committed to
providing quality care**

Managed
health

care plans

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The Boston Globe

Breakthrough for a US health plan

The key players who will shape a national health plan, including a former President Nixon, is a top adviser to the coalition of groups that is pushing for a play-or-pay system.

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WHETHER IT'S AT CITY HALL, IN the grocery store, between innings of a ball game, or on the campaign trail for the highest elected offices of this country, one topic has touched Americans and captured their attention like no other: health care. How to supply, deliver, and pay for medical services is high on the short list of Americans' concerns and promises to stay there for years to come. Indeed, politicians, who are often unfamiliar with the intricacies of modern health-care delivery, have been obliged to generate prescriptions for the system's ills. The likely sources of funding for a more comprehensive plan, how to deal with the masses of uninsured individuals, the role of government in regulating or even directing the health-care system—all these questions are now routinely debated by people who formerly concerned themselves with little more than how to get a parking space at the family doctor's office.

Thousands of fixes and remedies have been discussed and discarded; even more have been proposed. The health-care dollar has been thoroughly dissected and reconstituted on the federal operating-room table. Yet despite DRGS, RBRVS, and other abbreviated approaches to this long-standing concern, costs continue to rise while people drop from coverage rolls. Technology proliferates, often without the coordination and collaboration necessary to make the most efficient use of scarce resources. Needing to repay high educational bills and keep up with rising insurance rates, increasing numbers of doctors opt for subspecialization rather than for careers dedicated to providing the primary care that so many patients need and are unable to find. A rapidly growing elderly population is becoming disenfranchised, often falling through the "medi-gap" or holes in a fragmented service delivery system.

The Deaconess Hospital is not isolated from the dilemmas faced by health-care providers across the country. Many colleague institutions are seeking to attract more patients by broadening their service offerings, increasing the number of beds, and adding to their arsenal of technology. Others are expanding the geographic boundaries of primary care services. In this strained and sometimes contentious environment, the Deaconess Hospital is pursuing a path unique among, and complementary to, the region's academic medical centers. By remaining focused on the mission of delivering tertiary care to patients suffering from complicated diseases, the Deaconess provides the highest quality health services in a cost-effective setting. Yet, by following a tradition established in its earliest years, when the relationship with the Joslin Diabetes Center was forged, the Deaconess is working to meet the health-care challenge through partnerships and strategic alliances with others committed to providing quality care.

In recent years, the changing nature of health care has reinforced the importance of coordinating efforts with colleagues from outside the Hospital. Thus, the Deaconess has agreements with more than 140 organizations, including the nearby Dana-Farber Cancer Institute, and a number of Massachusetts community hospitals. Deaconess surgeons have initiated general and vascular surgery services at Beverly Hospital, and the Division of Vascular Surgery has established a joint affiliation with Falmouth Hospital. Other Deaconess physicians participate regularly in Tumor Board conferences at Sturdy Memorial and Southwood hospitals. Moreover, Deaconess researchers

participate in inter-institutional investigations to create more effective, valuable care for the nation's ill and elderly. All of these hospitals maintain primary and secondary services in the community with coordinated tertiary care at the Deaconess.

Other examples of valuable collaborations can be found in a variety of Deaconess endeavors. Through training, consultation, and financial assistance, the Hospital supports a number of worthy Massachusetts organizations, particularly those that serve older citizens and individuals at high risk of HIV infection. The Deaconess outreach program's strong financial and clinical training support assists community-based organizations and neighborhood health centers from Springfield to Provincetown. Administratively, the Hospital takes part in regional and national multi-institutional purchasing consortiums to serve patients with lower-cost, higher-quality medical supplies. At the local level, the Deaconess provides entry-level career training to inner-city youth through the Summer Jobs Program and Project ProTech, both sponsored by Boston's Private Industry Council. Numerous high-school-age students have received a head start on health-related careers through these programs, and several have continued as part-time Deaconess employees.

When the Deaconess Hospital and this growing network of partners confront today's ever-changing environment, the results are often surprising and creative. In its most recent and daring cooperative venture, the Deaconess has signed a formal agreement with The Nashoba Community Hospital, a 63-bed acute

care facility in Ayer, Massachusetts, which has become a subsidiary of the parent NEDH Corp. This arrangement provides residents of north central Massachusetts with the continued availability of primary care doctors, often fewer than ten minutes from their doors. At the same time, the sickest of Nashoba's patients will have a "seamless" transition to the care of Deaconess subspecialists—physician-scientists world renowned in the care and treatment of cancer, diabetes, cardiovascular disease, AIDS and other infectious diseases, organ transplantation, psychiatric illness, and other disorders.

Patients who rely on the Deaconess Hospital's intra- and extra-hospital network of caregivers will enjoy even greater access and comfort with the completion of the current extensive building project. When finished in early 1995, the 330,000-square-foot, 7-story Clinical Center, now under construction on the former site of Harris Hall, will enable the Deaconess to enhance its important role in the lattice of healing institutions—to give the best care possible to the sickest of patients. Construction will also begin on a new Research Building that will help the Deaconess continue to use biomedical investigation to produce more effective, affordable care. With these new buildings, the Hospital will bring its facilities closer to the ideal envisioned by founding Deaconess Mary E. Lunn nearly a century ago, a place "where science and kindness should unite in combatting disease."

The Na Comm

THE NASHOBA COMMUNITY Hospital is a true community hospital. Mission: to provide quality health care to the people in north central Massachusetts, roughly one hour northwest of Boston. As residents have maintained for years, the hospital has done an admirable job of fulfilling that purpose.

Gustav Jahn, eighty-three, moved from Clinton, Massachusetts, to Ayer some sixty years ago, where he went into business selling cars. Since that time, he has received a major portion of his health care through The Nashoba Community Hospital and one of its predecessors, Ayer Hospital. Nashoba is five minutes from his home, parking is ample, and staff know him by name. There was never a reason for him to go anywhere else, except when he had to undergo complex procedures that could not be performed in the community hospital setting.

"We are truly fortunate to have this hospital in our area," Mr. Jahn noted, after a visit to the office of his cardiologist, Terrence Hack, M.D.

While Mr. Jahn and thousands of residents like him from the communities served by the Hospital appreciate Nashoba's faithful support, most have little understanding of how tenuous the life of such an institution can be. Bottom-line-minded corporations have shifted their health-care contracts to managed-care organizations. Many patients have been redirected by the terms of their coverage to seek care outside their communities. With fewer patients, many small hospitals have been closing, merging, or converting to other purposes. These closures have the potential to leave large regions without broad-based hospital services nearby.

In an historic agreement for both institutions, the two hospitals decided to take another route. They joined forces in an arrangement that will allow The Nashoba Community Hospital to retain its local character while realizing the benefits of association with the Harvard Medical School-affiliated Deaconess Hospital. Unlike the Deaconess' other teaching and community hospital relationships, Nashoba has become a subsidiary of NEDH Corp. and has changed its name to the Deaconess-Nashoba Hospital.

The relationship is rich in opportunities for both institutions. The Deaconess is a "hospital's hospital," a referral center for the most complicated medical and surgical cases. To dilute that mission would alter the character of the Deaconess and reduce its unique value in the health-care system.

"We are dedicated to a focus on the difficult, complex, and unusual, particularly in patients with multiple problems or advanced diabetes, heart disease, cancer, or infectious disease," says Deaconess Hospital President and CEO J. Richard Gaintner, M.D. "All the best indicators of value—the number of patients treated, the average length of patient stay, and the intensity of treatment given to patients—all these show that we're doing complicated things more efficiently, while providing the best quality care and keeping expenditures in check. That's what value's all about."

Strong collaborative relationships with Deaconess physicians and departments have extended the services of highly trained specialists to an ever-widening group of patients and have helped community hospitals contend with the market forces that threaten them. The Deaconess-Nashoba connection will also lend efficiency and familiarity to the referral process and integrate activities throughout all departments and divisions of both hospitals.

"We're operating in a period when the mechanisms of care are all too often fragmented," says Deaconess-Nashoba Hospital President Jeffrey R. Kelly. "We've been through a time when hospitals attempted to be everything to everybody. What we found was that no one institution can do it all, but we do need connection with a much wider array of services than we alone can provide. If you look at the Deaconess Hospital and our hospital, you can easily see how we will complement one another."

Although frequently overlooked in clinical hospital interactions, continuing medical education promises to be one of the most productive collaborative enterprises. The explosion of information in the biomedical field has had an impact on the practice of medicine both in academic medical institutions and at community hospitals. Doctors, nurses, scientists, and therapists race to keep up with "the literature" of new research findings, yet the mountains of new information resist management. Gaps in the dissemination of new knowledge can have an impact on patient care.

Thus, continuing education is essential for all medical professionals. With his appointment as assistant to the president for medical education, Lee Simon, M.D., staff physician in Rheumatology and Harvard Medical

School (HMS) assistant professor of medicine, will begin coordinating Deaconess educational activities. Recognizing the need for timely, low-cost medical education programs at community hospitals, Dr. Simon will work with the Deaconess Hospital Speakers Bureau to share the latest in research and clinical developments not only with physicians at the Deaconess-Nashoba Hospital, but also with doctors at the many other community hospitals the Deaconess knows well.

Nashoba cardiologist Terrence Hack recognized that an association with the Deaconess could provide this type of opportunity for continuing education in his field, help Nashoba in the increasingly competitive marketplace, and improve the delivery of health services to his patients. Dr. Hack began working with Stan Lewis, M.D., Deaconess director of Clinical Cardiology and HMS clinical instructor in medicine, and eventually joined the Deaconess Hospital staff. Thus, he is able to see his patients with the most complicated problems as they are awaiting cardiac procedures, while the Deaconess cardiology staff provides a well-trained, familiar source of back-up care.

"For years I sent patients to all the Boston hospitals, and it just doesn't work," Dr. Hack says. "The patients are frightened, and sometimes they feel lost in the system because there's no link."

The connection formed by Drs. Hack and Lewis paved the way for a Pepperell, Massachusetts, resident to come to the Deaconess Hospital for catheterization and cardiac bypass grafting this year. The patient had a family history of heart disease but was without symptoms himself until suffering violent chest pains. An ambulance rushed him to The Nashoba Community Hospital where "they saved my life," he stated.

A week later he arrived at the Deaconess and was soon greeted by Dr. Hack, who performed a catheterization confirming an extensive blockage of arteries that supply blood to the heart tissue. Two weeks after the heart attack, Deaconess cardiac surgeon Karl Karlson, M.D., HMS assistant clinical professor of surgery, bypassed these clotted arteries in the operating room. Following the procedure, the patient returned to Nashoba for his rehabilitation program and monitoring.

By virtue of the formal agreement, this seamless flow of coordinated care between two cooperating institutions will be extended throughout all departments at both hospitals. Patients needing liver or pancreas surgery or specialized surgical care for conditions complicated by diabetes and other disorders will come to the Deaconess Hospital in the same orderly fashion that the gentleman from Pepperell enjoyed.

Both through the formal agreement with Nashoba and the less formal physician-to-physician and department-to-department programs, the Deaconess has endeavored to add value to today's health-care system. With each partner doing what it does best, the network avoids duplication of effort and delivers the highest quality care in the most effective setting.

"We're here to do the things that community hospitals can't do or don't feel comfortable doing," says Glenn Steele Jr., M.D., chairman of the Department of Surgery and HMS William V. McDermott Professor of Surgery. "We believe that this type of collegial relationship will achieve a higher level of service for many patients in the future."

THE Ayer 'unique

By PATRICIA W. MONTMI
Sun Staff

AYER — In a move called "the first of its kind in the state," officials of Nashoba Community Hospital and executives from Deaconess Hospital in Boston yesterday signed a "memorandum of understanding" designed to ultimately link the two hospitals.

At a noontime press conference at the Ayer hospital, executives from both hospitals announced that Nashoba would become a subsidiary of the Deaconess parent corporation, probably by Jan. 1.

What makes the agreement unique, officials said, is that the smaller hospital, Nashoba, would retain responsibility for appointing local trustees and medical staff and for the facility's operation, and not be entirely subsumed by the larger hospital.

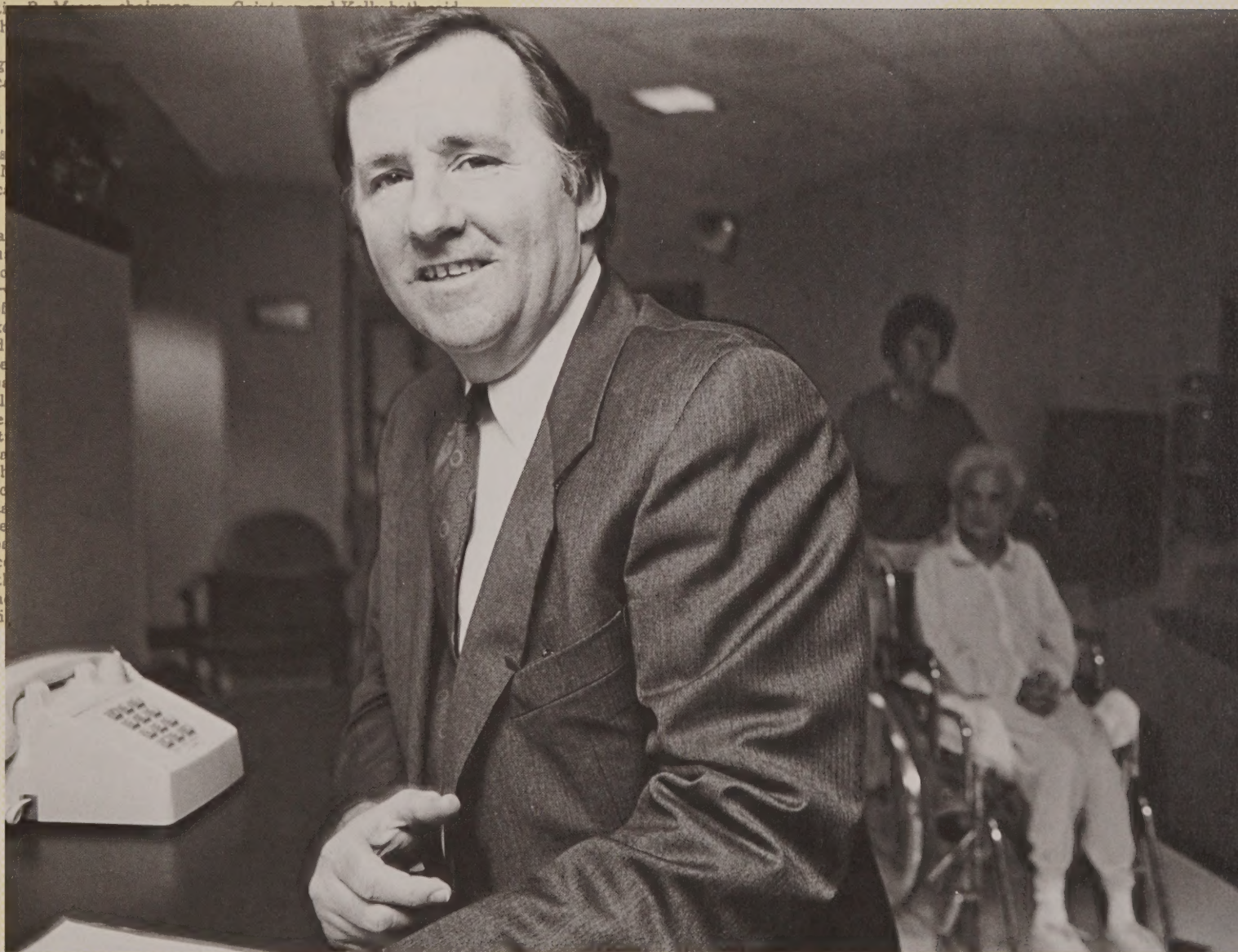
Avoiding the term "takeover" — he called it "a business page word" — Jeffrey Kellogg, chief executive officer of Nashoba, told reporters the discussions about the "alliance"

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**Nashoba Hospital
President
Jeffrey R. Kelly**

The New York Times

PRESIDENT'S PLANS FOR HEALTH CARE OUTLINED TO A.M.A.

EMPHASIS ON INCENTIVES

Administration Seeks to Control
Costs by Fostering Health
Maintenance Groups

RoxComp Executive
Director Jeanne
Taylor, Ph.D., and
Medical Director
Duane Smith, M.D.



ROXBURY COMPREHENSIVE COMMUNITY Health Center lies on Warren Street in Roxbury, one block from the Washington Square Mall. The Mall is one of the few places in this part of Boston where residents can find a supermarket and a discount store under the same roof. Bunker-like and windowless, it remains only as long as its profitability can be maintained in the face of urban poverty and resignation.

Like the Mall, RoxComp—as the health center is otherwise known—is a source of desperately needed and often scarce services for inner-city residents; the atmosphere within, however, is cheery, amiable, optimistic, and electric. An expectant mother comes in for prenatal care to find a bright atrium, with ficus trees growing in the lobby. Duane Smith, M.D., the busy medical director, shakes a visitor's hand. "We're happy to have you here," he says. "Take a look around."

There is much to see. RoxComp was created by the city to provide medical and dental services for the people of Roxbury and Dorchester—more than 200,000 Boston residents—regardless of their ability to pay. Its mission statement commits the health center to "...focus upon the needs of areas having high concentrations of poverty and inadequate health services; to coordinate existing services...; to provide total comprehensive health services; to engage in research and program development that is culturally and ethnically competent and which addresses the needs of our patient population; and to render social, educational, and other assistance needed by families and individuals..."

As the numbers of uninsured increase throughout Massachusetts and the nation, RoxComp's operation grows more challenging. Community health centers are responsible for greater amounts of unreimbursed care. Compensation rates for state and federal medical assistance programs have fallen dramatically, leaving community health centers with inadequate payment from those patients who are covered. Although RoxComp has balanced budgets for the last eight years, finding the staff, equipment, and other facilities to keep current with the needs of modern medicine has been a struggle.

In answer to growing responsibilities, RoxComp's leadership has made appropriate appeals to outside institutions for cooperative assistance. Thus, in 1985, Deaconess medical residents began rotating through the community health center. The program gives residents experience with primary medical care, while providing the Center with a source of free physician's services.

In 1989, Executive Director Jeanne Taylor, PH.D., came to the Deaconess seeking more substantive involvement. She met with Dr. Gaintner, who not only fulfilled her wishes for more resident hours, but also toured RoxComp and pledged the Deaconess' involvement on all appropriate levels. "I was impressed with his sincerity and at how quickly he followed up on everything he had promised," recalls Dr. Taylor. "I know that I can call Dr. Gaintner for consultation and be assured of a response."

The Deaconess Hospital has built its relationship with RoxComp in ways, which, while including financial contributions, have not been limited to traditional forms of support. For instance, Deaconess internist

J. Jacques Carter, M.D., M.P.H., HMS instructor in medicine, was appointed to an oversight and liaison position for the residency program to ensure better communication between the two institutions on educational issues. To provide a closer link for both RoxComp physicians and their patients, the Center's medical director Dr. Smith was granted admitting privileges at the Deaconess Hospital in 1991. When Dr. Taylor began searching for a chief operating officer to work with her at the health center, the Hospital provided a search agency and individual consultation. Recently, Deaconess staff has played an important role in planning and organizing the 1993 RoxComp fund-raiser chaired by Dr. Gaintner.

Now the Deaconess is taking even more fundamental steps to help RoxComp surmount the challenges and to ensure its continued effectiveness and success, and the true winners are RoxComp's patients. They benefit from the availability of an on-site radiology facility, allowing for quick, local X-ray services which are read daily by Deaconess radiologists. Deaconess physicians, scientists, and nurses supply training in serving older patients or people with AIDS and other specialized diseases. In addition, Hospital staff has covered for RoxComp personnel in emergencies, obviating interruptions in patient care; the augmented medical aid of Deaconess residents helps RoxComp provide more high-quality care, free of charge, to the neediest individuals and their families.

Although Deaconess medical residents are vital to ensuring that patients gain access to needed health services at RoxComp, at the same time, rotating through the health center adds essential experience to their own training. While the Deaconess serves patients suffering

from cancer, HIV-related illnesses, heart disease, and other complicated disorders, RoxComp's clientele walk in the door with colds, flus, respiratory infections, substance-abuse problems—a universe of medical conditions. "It's the whole spectrum of disease," says Nicholas Rencricca, M.D., a second-year Deaconess resident. "These people come in needing help of all kinds."

At the age of fifty-one, Dr. Rencricca is what is known as a "mature resident." Seven years ago he decided to leave a rewarding career in teaching and research hematology at the University of Massachusetts at Lowell, where he was dean of the College of Pure and Applied Science, to pursue a degree in medicine.

At RoxComp, Dr. Rencricca has found exactly the type of medicine he wants to practice. "I feel right at home," he says. "I was coming here one afternoon a week, but then I requested a full two-week elective rotation so that I could spend more time here. After I'm done with my training, I'll try to find some place like this where my services are really needed."

The relationship with RoxComp and the growing residency program have likewise enhanced the Deaconess and its role as an academic medical center. Expanded educational opportunities enable the Deaconess to contribute to alleviating the shortage of primary care physicians—a difficult mission for a fundamentally tertiary care institution. David R. Calkins, M.D., M.P.P., chief of the Division of General Internal Medicine and HMS assistant professor of medicine, has begun expanding the Deaconess faculty, adding five physicians within the last year alone. According to Dr. Calkins, the Division's growth will provide greater training opportunities for primary care doctors.

In addition, the Hospital's arrangement with managed-care settings such as HMO Blue will give these trainees exposure to the kind of cost-effective medicine necessary in the managed-care environment. Jeannette M. Shorey, M.D., director of Ambulatory Education for the Department of Medicine and Division of General Internal Medicine and HMS instructor, will be involved in restructuring the internal medicine program so that participants spend more time learning about the world of ambulatory care. Perhaps most important, these trainees will also be the physicians who fill the dire need for primary care doctors in settings such as RoxComp.

This unconventional marriage of public and private health-care providers is founded on an open dialogue that addresses the pressing issues of medicine today and a shared desire to increase access to the vast array of health services. Since her appointment to the Deaconess Hospital Corporation and Board Planning Committee in 1991, Dr. Taylor has provided an important perspective on issues relating to outreach and treatment for urban residents.

"This is a model for empowerment of a community agency," says Dr. Taylor. "It's rewarding to the Center to be treated as an equal, with the respect and regard of a peer in the business of providing medical care, and not merely as a place upon which favors are bestowed. The Deaconess Hospital is genuinely interested in what we have to say and in having us as partners."



The Boston Globe

Longer Life The next frontier



THE HEALTH-CARE SYSTEM HAS become increasingly complex, compelling patients to participate more actively in coordinating their own care. The more an individual uses the system, the more complicated and confusing it may get. People over the age of sixty-five seek medical care three times more often, are hospitalized three times as frequently for twice as long, and take double the amount of prescription drugs as people under that age. While many older adults successfully navigate the intricacies of the system, for some, the process itself, added to their medical conditions, can lead to a functional decline.

Throughout his almost 20 years as a physician, John R. Delfs, M.D., HMS assistant professor of medicine, had observed frustrating episodes in which certain older patients arrived at hospitals able to function in their homes—cooking, cleaning, dressing themselves—but left with new problems which compromised their ability to live independently. While many were helped by the accomplishments of modern medicine, others had lost their independence, and some may have commenced cycles of re-hospitalization that would last for the rest of their lives. Although the surgical or medical procedures were successful, the individuals had been forever changed by their hospital experiences.

After closer examination, Dr. Delfs recognized that there was no single reason underlying any of these cases. These sometimes frail patients may simply be more vulnerable to life's crises. Disruption of their daily lives and routines can make it difficult for them to continue functioning independently. The urgency of addressing

medical problems must be considered in the context of ensuring that these patients remain vital and well oriented and that their friends, family, and other forms of support are included and maintained.

Deaconess ElderCare came into being to fill this critical need for coordinated, compassionate care for older patients. Since its creation in 1990, staff members of Deaconess ElderCare have ensured that these issues are recognized and addressed and that the qualities of life patients hold most dear—dignity, independence, mobility, social interaction—are not disrupted during a hospital stay. Inpatient, outpatient, and outreach programs implemented by an interdisciplinary team of physicians, nurses, and social workers specializing in gerontology have all been designed to construct a continuum of care for older individuals. For Deaconess ElderCare patients, that continuum may begin before hospitalization and may last even after they return home or move on to another care setting.

The Deaconess ElderCare Service screens patients upon admission to the Hospital to determine whether they are at risk of losing the ability to function independently. The service—an interdisciplinary team approach to treatment which often includes other Hospital clinicians such as pharmacists, nutritionists, and rehabilitation specialists—designs and supports effective care plans developed in conjunction with the patient's primary care physician.

Many other Deaconess departments have developed complementary programs which contribute to the special care provided to older adults. For example, the Department of Psychiatry, under the direction of Clinical Director Andrew W. Brotman, M.D., HMS associate professor of psychiatry, participates when older patients' problems are complicated by dementia, thought disorders, insomnia, or depression. "Our approach is to look at what potential problems are reversible, recognize those that are non-reversible, and identify those that are really symptomatic. We then work with the family to integrate psychiatric, medical, behavioral, and psycho-pharmaceutical treatments," says Dr. Brotman.

Deaconess nursing is a focal point for bringing older patients the care they need to return to their homes and families. As the gerontological nurse practitioner observes, Deaconess nurses assess and identify issues that consistently arise among their older patient population. For example, "lines of communication" often must be established with a family spokesperson. Further, many older people are themselves caregivers for spouses, which often influences their perspective on their own needs for medical attention. The understanding that the patient may be someone else's care provider calls for both special skills and creative new approaches to care designed to maximize patients' functional independence.

Deaconess nurses who care for the Hospital's predominantly older patient population are vital in implementing care plans developed in cooperation with the ElderCare Service for individuals whose functional capabilities are at high risk. Nurses make a constant effort to keep the climate of care consistent and nurturing. With the benefits of therapy rendered by the Hospital's expert clinicians and of support systems organized by social workers and continuing care nurses, patients leave the Hospital with a realistic goal of regaining the capabilities with which they arrived.

To supplement inpatient programs, the Hospital has opened a 23-bed Transitional Care Unit (TCU), located at the neighboring Joslin Diabetes Center. The TCU will provide a supportive environment for patients who may no longer need acute hospital care but who are not ready to go home. Senior Vice President for Patient Care Services Judy Miller, M.Ed., R.N., observes that older surgical patients, particularly those suffering from diabetes and other complicating illnesses, will continue to receive expert attention from the Deaconess staff without remaining in the acute-care setting.

Deaconess ElderCare also has a Community Care Coordination Service which arranges for home assistance and medical care from a variety of local agencies when patients in the program are ready to be discharged. The team follows up to ensure the coordination of support services necessary to enable the patient to regain the maximum extent of independent function possible. "The essence of ElderCare is to bring institutions and services together around the needs of the patient," says Dr. Delfs. "To give this type of patient-centered care, it's essential—not optional—to cooperate and collaborate with other health-care organizations."

This continuum of care also extends outside the Hospital into the community through educational activities. The Deaconess co-sponsors the Massachusetts Elderly Injury Prevention Program, under the direction of Dr. Alan Balsam of the state Department of Public Health. Other educational activities include presentations to community and professional groups on health-care decision making and the role of the Health Care Proxy. In cooperation with community organizations, programs are being developed for patients, families, and caregivers on health issues and care for older adults.

Deaconess ElderCare also provides medical coordination for the Alzheimer's Disease Program at Sherrill House, a nursing home in Jamaica Plain, and health-care support at Burrage House, an assisted-living facility on Commonwealth Avenue in Boston. The services at the renovated Back Bay mansion enable residents who need personal care assistance to retain their independence and dignity in a communal environment.

These community programs help to keep productive, capable elderly patients from needing hospitalization for as long as possible while allowing the Deaconess to find new ways to provide health-care services for this growing population. This goal is supported by ElderCare's new interdisciplinary Geriatric Assessment Center, which screens elderly outpatients for risk of functional loss and provides consultation to their primary care physicians.

The programs developed by Deaconess ElderCare help patients like Annie M. Beaumont. Mrs. Beaumont and her husband, Galvin, were driving home from their fiftieth wedding anniversary celebration when he slumped over at the wheel, dead of a heart attack. The sudden end to a wonderful marriage was a deep shock to Mrs. Beaumont, who has lived contentedly on the same suburban street in Kearny, New Jersey, for 75 of her 78 years.

In retrospect, Mrs. Beaumont thinks her husband's death may have had something to do with incidents that she began experiencing earlier this year. She found it harder to balance her checkbook; the papers just ended up all over the floor. Her children thought they heard slurring of her speech. "I would have to admit that there was something not right with me at that time," says Mrs. Beaumont. "I just seemed to get mixed up."

Mrs. Beaumont's daughter, who lives in Newton, Massachusetts, brought her mother in for evaluation. She was seen by Dr. Delfs, who admitted her for a series of tests and treatment of skin ulcerations on her leg. Her evaluation included consultations with other Deaconess specialists, and evidence pointed to Mrs. Beaumont's having had a transient ischemic attack, or "mini-stroke," that temporarily clouded her thinking. She was treated with a blood-thinning drug that decreases the likelihood of further such problems and received self-care information from the team nurse. The family also received education and support from the team social worker before Mrs. Beaumont's discharge.

With the dramatic increase in the number of seniors and the concurrent value placed on independence among this "greying" population, programs like Deaconess ElderCare can have a tremendous impact on both the health and well-being of older adults. With the participation of individuals and their families, caregivers work to help older patients retain their independence and control over their own lives. For some, like Annie Beaumont, it can make a real difference. "I don't think there's an inch of me that they don't know something about," Mrs. Beaumont says. "I really feel better now."

The New York Times

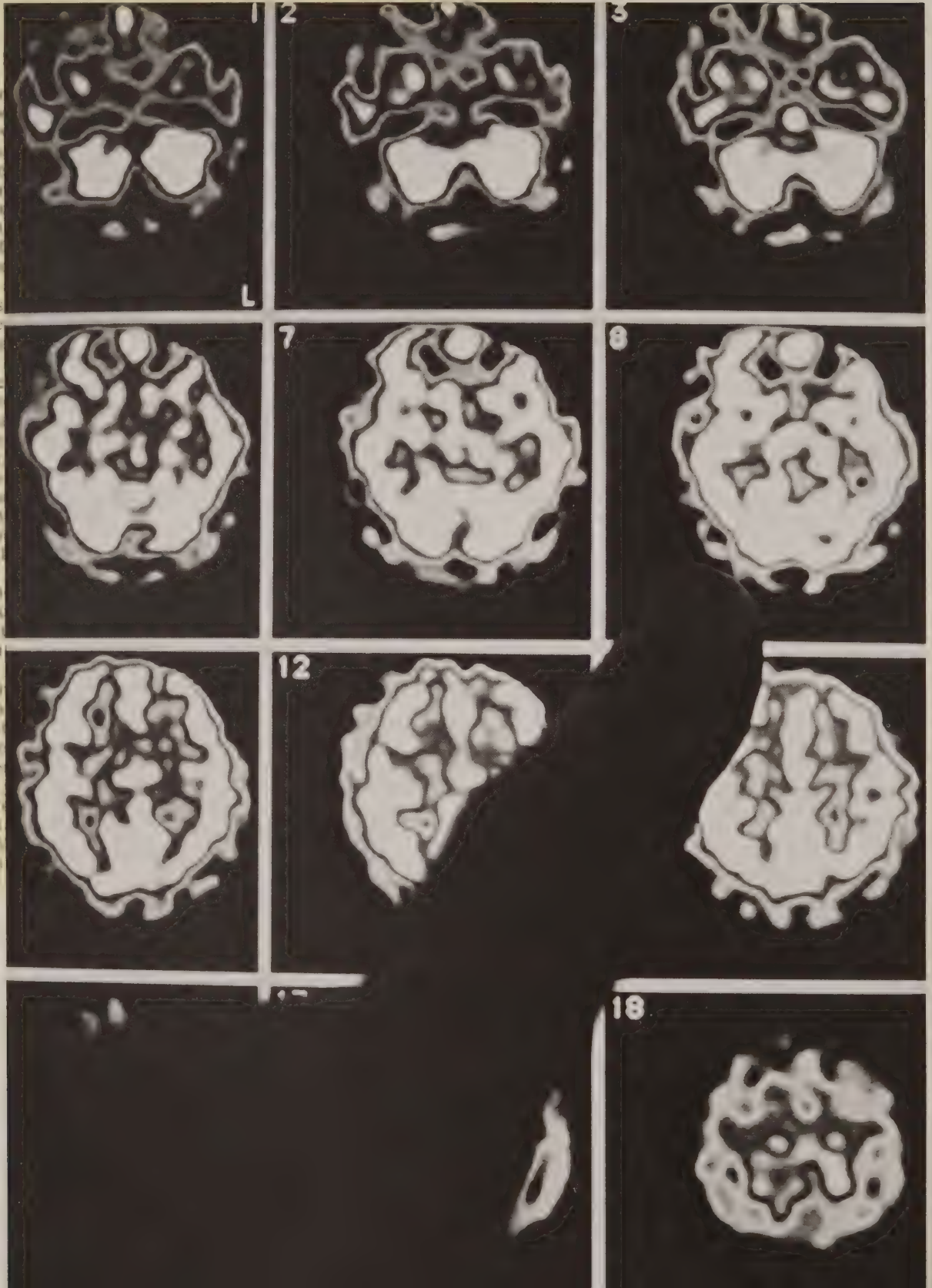
Hospital Study Tests Benefits Of Giving Comfort With Care

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RESEARCH AT THE DEACONESS IS A means by which the Hospital brings greater health-care value to patients. Deaconess researchers constantly re-examine all aspects of the care process, including the systems by which care is delivered, the therapies that patients receive, and the understanding of the human body and its illnesses upon which those therapies are based. Through the Hospital's continuous quality improvement initiative, the support services that permit these important hospital processes to take place are also critiqued and improved by employees.

The Deaconess Hospital is proud of its researchers and their programs, particularly the extent to which staff and employees work in interdisciplinary and inter-institutional collaborations. Examples of these coordinated efforts may be found throughout the Hospital. The Department of Surgery recently announced that Deaconess vascular surgeon Frank W. LoGerfo, M.D., HMS professor, will be leading a National Heart, Lung, and Blood Institute-funded research training program in peripheral vascular surgery. Four Longwood Medical Area institutions—the Beth Israel, Brigham and Women's and Children's hospitals and the Joslin Diabetes Center—will join the Deaconess in the effort. This is the first such surgical grant funded by any branch of the National Institutes of Health.

Under the leadership of Glenn Steele Jr., M.D., himself a renowned researcher in the area of colorectal cancer, and Anthony P. Monaco, M.D., head of transplantation at the Deaconess and HMS professor, the Department of Surgery launched

international collaboration with the recruitment of transplant immunologist Fritz Bach, M.D., currently an HMS visiting professor. A native of Vienna, Dr. Bach studied at both Harvard University and the Medical School and trained under eminent physician, scientist, and author Dr. Lewis Thomas. Dr. Bach has been a pioneer in the study of the cells involved in rejecting foreign tissues. The new Deaconess research program, funded in large part by a grant from Sandoz Pharmaceutical, will focus on creating greater supplies of potential organ grafts and will work in concert with another Sandoz laboratory established by Dr. Bach in Vienna.

In the Department of Anaesthesia, Chairman Ellison C. Pierce Jr., M.D., HMS associate professor of anaesthesia and President of the Anaesthesia Patient Safety Foundation, has emphasized safety as a central theme of his department's research efforts. Preliminary results of a 700-patient, 4-year study led by Deaconess anaesthesiologist Robert H. Bode, M.D., HMS clinical instructor, have shown that general anaesthesia is just as safe as a regional anesthetic in high-risk vascular surgery patients. The finding gives physicians a greater array of choices when caring for these individuals. In a new study under the direction of Keith Lewis, M.D., HMS clinical instructor in anaesthesia, the Deaconess has recently been chosen as one of ten medical centers to investigate the use of newer inotropic agents to improve the management of patients during open-heart surgery.

Dr. Pierce's emphasis on safety also extends to educational activities, most recently with David Gaba, M.D., of Stanford University, who has brought an important anaesthesia training research program to the Deaconess Hospital. A number of Harvard anaesthesiologists joined to observe and participate in this instructional system in which an authentic operating-room environment is created with OR monitors controlled from outside, "actors" playing nurses and doctors, and a dummy substituting for the patient. The life-like recreation of a pressure-laden anaesthesia experience allows residents and senior staff to work through—and prepare for—operating room "worst-case scenarios" that they would seldom encounter under normal circumstances. In one situation, a patient displays "hyperpyrexia," a rare reaction to certain forms of anaesthesia, during which the patient's body temperature rises uncontrollably. In another simulation, the electricity to the operating room is cut, challenging the trainee to find a way to cope while keeping the patient safely anesthetized. This is a powerful teaching method that will soon enjoy much wider use and increase safety in anaesthesia training.

Both clinical and laboratory research continues in the Department of Medicine as well. As chairman of the department and HMS Shields Warren-Mallinckrodt Professor of Medical Research, Robert C. Moellering Jr., M.D., has led research activities toward more effective therapies for cardiovascular disease, HIV-related disease, and many other areas. His own investigations into how enterococci cause dangerous infections in hospitalized patients have increased knowledge about these treatment-resistant bacteria.

Cardiologist Victor Gurewich, M.D., HMS associate professor of medicine, has spent years studying a substance that could provide cost-effective therapy for heart attacks. Pro-urokinase, one of the body's natural clot-dissolvers, was discovered by Dr. Gurewich in 1979. Pro-UK, as it is called, is relatively inexpensive to produce and has the potential to act longer and more safely than some other widely used clot-breaking drugs.

Throughout the Hospital, researchers are currently involved in a myriad of studies that balance effectiveness and cost. For example, when administered as a drug, the hormone erythropoietin can save lives; by stimulating red blood cell formation, it can help patients cope with HIV-related disease, kidney disorders, anemias, and many other conditions. Yet, the drug itself is particularly costly. Among the many research projects of Deaconess hematologists, the work of Arthur Sytkowski, M.D., HMS associate professor of medicine, may eventually make erythropoietin more affordable. Eight researchers working with him in the laboratory are studying portions of the erythropoietin molecule to determine how long and how hard it works. The multi-faceted studies use chemical and genetic techniques to increase erythropoietin's potency and lifetime in the body. Dr. Sytkowski hopes that this will make smaller, less costly doses of the hormone effective in patient care.

Applying basic research is crucial in the fight against HIV. One of the most poignant tragedies of the HIV epidemic occurs when the virus is passed from mothers to their fetuses. Right now there is no way to predict which children of infected mothers will be born with the virus and which will be spared. Although little is known about this process, oncologist Marshall Posner, M.D., HMS assistant professor of medicine, has begun col-

laborating with researchers from the Dana-Farber Cancer Institute and Children's Hospital to study and prevent this form of transmission. The research team is working with a human monoclonal antibody called F105, a type of immune substance that can be manufactured in large amounts and responds to specific proteins created and carried by the virus. F105 reacts with proteins found on the surface of the HIV virus that are used to infect the host cell. Test-tube studies show that F105 blocks the virus from binding to this cell—the first step of the viral infection. Dr. Posner is hoping that treatment with such antibodies might alleviate some of the tragic burden borne by mothers infected with HIV and possibly prevent transmission to the fetus.

In Radiology, the pace of innovation has been furious, and the Deaconess—one of the first American hospitals to use single photon emission computed tomography (SPECT)—has remained in the forefront of academic institutions studying new technologies. Physician-scientists in the Hospital's Department of Radiology, under the direction of Chairman Melvin E. Clouse, M.D., HMS professor of radiology, have brought patients new technologies, applying them in ways that increase their value. In the laboratory, Dr. Clouse and others have a National Institutes of Health grant to study the effect of cold ischemic storage of the donor liver prior to implantation as a way to improve function once implanted. In the clinical sphere, George Hartnell, F.R.C.R., F.A.C.C., HMS associate professor of radiology, came from the United Kingdom to investigate new ways of using minimally invasive forms of cardiac imaging. In magnetic resonance imaging (MRI), Dr. Hartnell believes he has found a technique with the potential to do

just that. Cardiac MRI allows accurate, comprehensive, and relatively inexpensive studies which are particularly suited to elderly or vulnerable patients, with no catheters, limited use of contrast dye injections, and few complications.

In a similar way, the researchers in the Departments of Radiology and Psychiatry continue to collaborate on productive uses of imaging techniques in diagnosing and treating mental illness. Thomas C. Hill, M.D., HMS associate professor of radiology, and Russell G. Vasile, M.D., HMS assistant professor of psychiatry, have used SPECT technology to evaluate psychiatric patients' responses to therapies. These studies may enable physicians in the future to choose the most efficient treatments for depression and other psychiatric conditions.

Under the direction of Harvey Goldman, M.D., HMS professor and faculty dean for medical education, the Department of Pathology remains at the forefront of clinical and investigative pathology. For instance, the discipline of genetics has changed the face of modern medicine and made its impression in each of the Hospital's research programs. Steven R. Tahan, M.D., and Massimo Loda, M.D., both HMS instructors in pathology, use molecular biology to bring more accurate techniques to the diagnostic laboratory. Dr. Tahan has recently shown that a protein called "proliferating cell nuclear antigen" or PCNA, found in rapidly growing cells, can be used to distinguish more aggressive breast cancers from less threatening tumors. He has assembled an extensive bank of tumor tissue which he is also using to study the importance of newly discovered growth factor and tumor suppressor genes to define what is significant in the development and treatment of cancer cells.

A similar bank of stored tissue helps Dr. Loda explore how receptors of somatostatin are involved in cancer cell proliferation. Somatostatin is a naturally occurring hormone that slows or limits cellular growth and is currently used to treat certain pituitary tumors. Dr. Loda hopes that other tumors that are susceptible to treatment with somatostatin can be diagnosed and treated using molecular biological means.

Bringing basic science to the clinical setting has had a significant impact on the Department of Radiation Oncology, located at the Joint Center for Radiation Therapy, which celebrated its twenty-fifth year of operation in 1992. Chairman C. Norman Coleman, M.D., Alvan T. and Viola Fuller American Cancer Society Professor of Radiation Oncology, recently formed the Harvard Longwood Oncology Group (HLOG), a multi-institutional research and training consortium. HLOG will help researchers such as Deaconess radiation oncologist Mary Ann Stevenson, M.D., PH.D., HMS assistant professor of radiation oncology, who is studying cellular responses to radiation treatment. Her work may point out ways to reduce cancer cell resistance to radiation treatment.

Research has become an important component of the compassionate, professional nursing care that is a signature of a Deaconess Hospital patient visit. The growth of the Center for Nursing Research has allowed nurses to evaluate nursing systems and raise the level of patient comfort and care from year to year. Deaconess nurses have studied a wide array of subjects, often working with outside institutions to solve important health-care problems. While new bedside technologies raise the nurses' ability to monitor and track a patient's progress, attitudes often can limit use and acceptance of such caring technologies. In one study, Mary Doucet, R.N., and Anne DeStefano, R.N., Intensive Care Unit (ICU), measured attitudes of surgical ICU nurses before and after the implementation of bedside computers. The study identified preconceptions that had an impact on the computers' utility in this setting.

With greater support from federal and private sources than ever before, Deaconess Hospital researchers can give more attention to the fundamental needs of the health-care system: how to work with the institutional community to coordinate care, how to maximize the system's ability to treat everyone who needs it in a cost-effective fashion, and how to ensure that patients receive care that is worthy of their dignity and needs. Deaconess leadership has dedicated the Hospital to following this path of discovery.

1992 WAS AN OUTSTANDING YEAR FOR the Deaconess in every respect. The campus redevelopment plans moved closer to reality as construction commenced on the new Clinical Center. The Joint Commission on the Accreditation of Health Care Organizations (JCAHO) review was completed this fall and the Deaconess received accreditation with commendation—an honor given to fewer than six percent of the hospitals nationwide. We finished the year with a strong financial performance. There were 500 more discharges than last year. Case mix intensity continued to rise; length of stay continued to decline; and more people were served in both the emergency room and outpatient clinics. Most important, we continued to provide the high-quality, individualized care for which the Deaconess has become known.

This exemplary performance is a tribute to the strength of our employees, our programs and our collaborative working relationships—within the Hospital, with our Longwood Medical Area neighbors, with doctors, hospitals and health centers throughout Massachusetts, and with the community at large. This has been a team effort—physicians, nurses, scientists, employees, trustees, corporators, volunteers and friends—have all worked to do better what they already do so well. This is the essence of continuous quality improvement and the spirit of the Deaconess.

As we approach the 21st century, we are a part of a health system undergoing tremendous change. We must keep pace with the challenges of this environment, and we must work to make the health care system more responsive to the needs of patients and the community. For the Deaconess, this means concentrating on research, education, and providing the highest quality care to the sickest patients. It also means working with community hospitals, health centers and other care providers to share our specialized skills and support their activities. Not only is this the subject of our annual report, but it is also our vision for the health care system and the role of the Deaconess in that system. This is the way we can ensure value, quality and a continuum of care for all patients.

The benefits of collaboration began with the partnership between the Deaconess and Joslin Diabetes Center many years ago and continue with the new relationship of the Deaconess with Nashoba. Collaboration will grow and evolve in response to both human need and new scientific discoveries. Last year's annual report stated that we must "strive to do all that we do with greater efficiency and effectiveness... sustaining and increasing the value of the services we provide." This remains a focus for the Deaconess and one that will allow us to make a vital contribution to tomorrow's health care system and to our society.

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J. Richard Gaintner,
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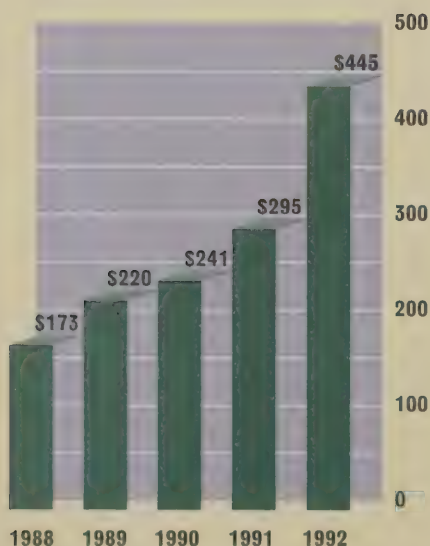
	1992	1991*
Condensed combined balance sheets		
September 30, 1992 and 1991		
<i>(dollars in thousands)</i>		
Assets		
Current assets	\$ 121,706	\$ 94,384
Investments, etc.	210,864	117,404
Property, plant, and equipment (net)	112,186	82,938
Total assets	<u>\$ 444,756</u>	<u>\$ 294,726</u>
Liabilities and fund balances		
Current liabilities	\$ 76,829	\$ 61,428
Other liabilities	48,017	49,914
Long-term debt	170,121	68,985
Fund balances		
Unrestricted	98,376	72,077
Restricted	51,413	42,322
Total fund balances	<u>149,789</u>	<u>114,399</u>
Total liabilities and fund balances	<u>\$ 444,756</u>	<u>\$ 294,726</u>

*Fiscal 1991 amounts have been restated as a result of the adoption of a new single page reporting format of the balance sheet in the fiscal 1992 audited financial statements.

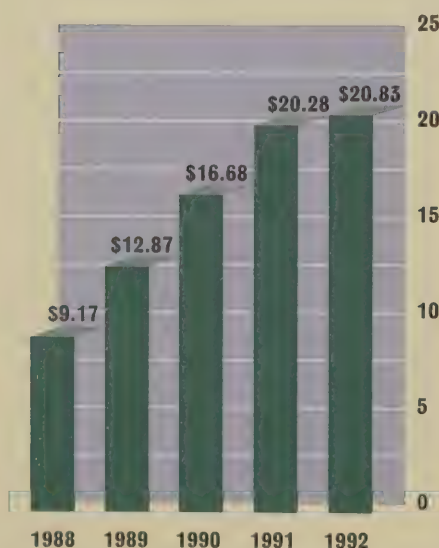
	1992	1991
Condensed combined statements of revenue and expenses		
September 30, 1992 and 1991		
<i>(dollars in thousands)</i>		
Total revenue	\$ 264,185	\$ 248,823
Total expenses	261,716	238,960
Income from operations	<u>2,469</u>	<u>9,863</u>
Non-operating gains before non-recurring gain on sale of assets	4,345	4,187
Revenue and gains in excess of expenses before non-recurring gain on sale of assets	6,814	14,050
Non-recurring gain on sale of assets	20,328 *	0
Revenue and gains in excess of expenses	<u>\$ 27,142</u>	<u>\$ 14,050</u>

*Represents the gain on sale of selected assets of Deaconess Home Health Care Corporation (renamed DHHC Corp.) to Total Pharmaceutical Care, Inc., on February 24, 1992.

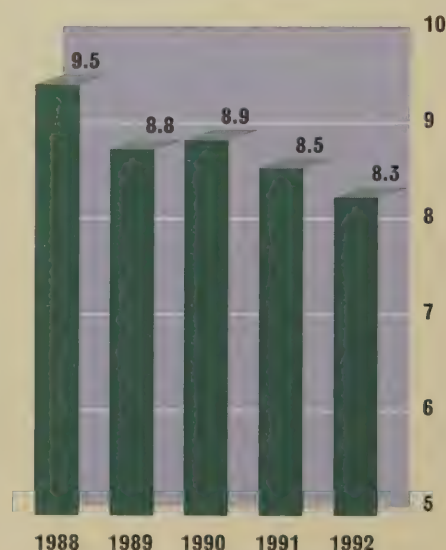
**NEDH Corp. and Subsidiaries
Combined Total Assets**
(Dollars in millions)



NIH and Other Supported Research
(Dollars in millions)



Average Length of Stay
Decreasing trend preferable
(In days)



**Operating statistics
Fiscal years 1988-1992**

	1988	1989	1990	1991	1992
Deaconess Hospital					
Discharges	13,743	13,710	12,897	12,324	12,822
Case mix adjusted discharges ¹	21,164	21,798	21,022	21,813	23,592
Patient days	129,924	121,056	114,732	104,434	106,491
Average daily census	357	333	309	286	291
Average length of stay (days)	9.45	8.83	8.92	8.47	8.31
Case mix—all patients ²	1.54	1.59	1.63	1.77	1.84
Medicare case mix ³	1.79	1.80	1.85	1.92	1.99
Total surgical cases	7,806	8,265	7,610	7,477	8,178
Surgical cases—inpatient	56%	53%	58%	59%	54%
Outpatient visits	32,630	38,350	33,475	33,843	38,703
Emergency room visits	6,169	6,191	5,863	6,260	7,601

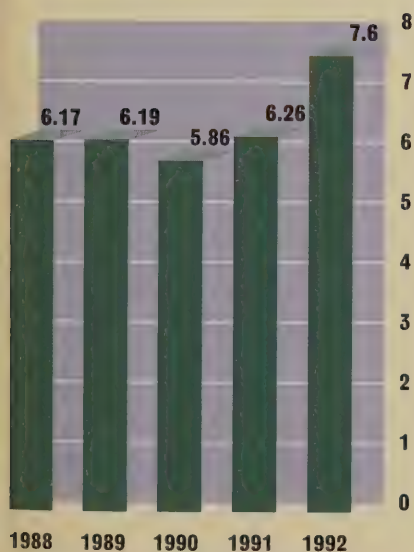
**Deaconess Professional
Practice Group, Inc.**

Occasions of service⁴

Deaconess Surgical Associates	44,640	35,701	45,183	49,177	50,983
Deaconess Medicine	77,818	101,993	146,858	146,989	148,510
Deaconess Radiology Associates	73,972	82,989	84,317	85,760	91,242
Deaconess Pathology Associates ⁵		4,046	37,031	40,704	52,299
Deaconess Psychiatry ⁶					10,880

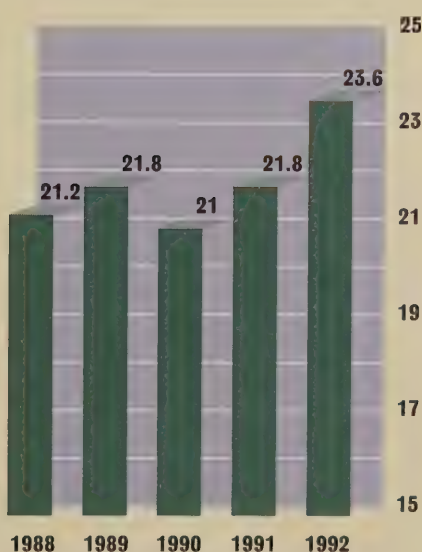
1. Discharges multiplied by an intensity factor representing the severity of illness and relative resource consumption of caring for patients as determined by the Medicare program. This composite value is an estimate and subject to change due to payor audits.
2. Intensity factor representing the severity of illness and relative resource consumption of caring for patients as determined by the Medicare program as applied to all patients.
3. Same as Note 2, applied to Medicare patients only.
4. Occasions of service is comprised of the following: office visits, hospital visits, consultations and office procedures.
5. Deaconess Pathology Associates joined the Physician Group in August, 1989.
6. Deaconess Psychiatry joined the Physician Group in 1992.

Emergency Room Visits
Increasing trend preferable
(In thousands)



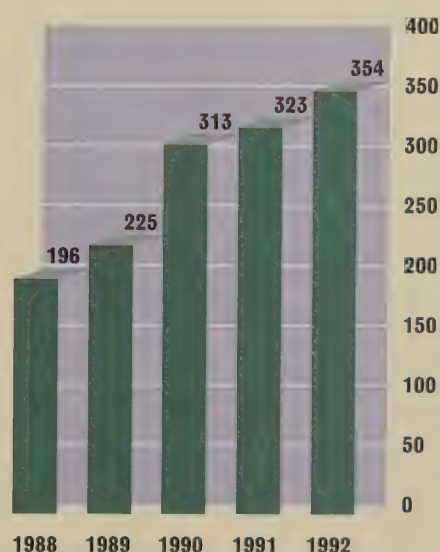
Case-Mix Adjusted Discharges

Number of discharges multiplied by an intensity factor representing the severity of illness and relative resource consumption of caring for patients as determined by the Medicare program.
Increasing trend preferable
(In thousands)



**Deaconess Professional Practice Group, Inc.
Occasions of Service**

Office and hospital visits, consultations, and office procedures
Increasing trend preferable
(In thousands)



NEDH Corp.

*As of 1992, prior to January
28, 1993, Annual Meeting*

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SPECIAL PULL-OUT SECTION

For Those Who Will Follow

THE DEACONESS CAMPAIGN



The war against disease is one which will never end, and although many of its combatants eventually die, some who have fought disease in their own lives and bodies are moved to help the others who they know will follow them.

Such a person was Robert Slaughter, a New York City lawyer and father of four whose battle against cancer brought him to the Deaconess Hospital. A vigorous, athletic man who played squash into his 60s, Mr. Slaughter was diagnosed with colon cancer in 1990. When his doctors removed his colon tumor, they detected, unfortunately, that the cancer had spread to his liver.

Chemotherapy, which began immediately, was unable to slow the liver tumor's progress. Mr. Slaughter came to Boston for counsel from Harvard Medical School (HMS) Dean Daniel C. Tosteson, M.D., and Emil Frei, M.D., of the Dana-Farber Cancer Institute. They referred him to Glenn Steele Jr., M.D., HMS William V. McDermott Professor of Surgery and chairman of the Deaconess Hospital Department of Surgery.

The tumor had grown to a point where removal would present a severe risk. In July 1990, Dr. Steele treated Mr. Slaughter cryosurgically, killing the tumor tissue with a freezing surgical probe. "I can only tell you that before the operation Dr. Steele told us the facts of life," recalls James Slaughter, the patient's brother. "He didn't paint any rosy picture, but he wasn't pessimistic either."

The procedure eradicated the liver cancer, but other tumors soon sprang up to take its place. In August, Dr. Steele attempted to resect these lesions, but it became clear that more surgery would probably provide no additional benefit. Mr. Slaughter died February 27, 1992.

Before his death, however, Mr. Slaughter took steps to ensure that others with complicated illnesses such as his would be able to receive the Deaconess Hospital's specialized care. He provided for the Goldsmith Foundation to donate \$500,000 to The Deaconess Campaign. Established by Mr. Slaughter's stepfather, the Goldsmith Foundation supports notable health care institutions around the world.

"My brother was very appreciative of the care he received at the Deaconess," says James Slaughter. "He thought very highly of his doctors and nurses, everyone who took care of him while he was there."

The Deaconess Hospital's reputation for specialized care has spread throughout the region, the United States and the world: no other Boston adult teaching hospital receives so many patients who have been referred from outside Massachusetts as well as from other hospitals.

Summer

Kennedy Ambulatory
Care Center
renovation complete

Spring

Clinical Center ground-breaking
Lowry Medical Office Building Lobby
renovations complete

Summer

Harris Hall demolition
Palmer 5 and Deaconess 4
renovated for Psychiatry expansion

Spring

Research facility schematic
design complete

Summer

Clinical Center structural
steel complete

1990 1991 1992 1993

Winter

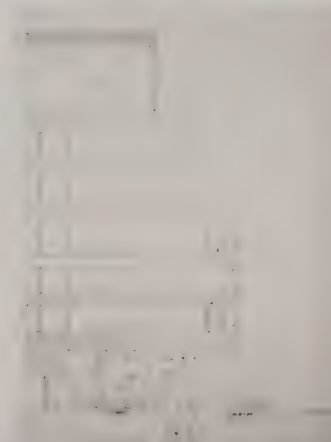
Brookline Avenue retail shops
demolished

Autumn

Clinical Center foundation work
complete

Winter

Farr Elevator expansion
begins



The Deaconess is unusual in its approach to health care in that it has never attempted to provide services for all medical conditions; rather, it has cultivated its expertise in caring for patients suffering from the most complicated and difficult-to-treat forms of disease. Diabetes, cancer, cardiovascular disease, HIV and other infectious diseases, organ transplantation and nutritional problems, for example, have all borne the scrutiny of Deaconess Hospital physician/scientists, and have all yielded to some degree in the form of new therapies, diagnostic techniques, and the understanding of underlying disease principles.

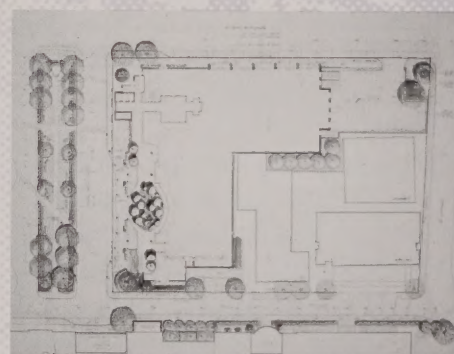
Achievement of the Hospital's mission has placed more demands on the setting in which care is delivered and research is pursued. Beginning in 1986, the Deaconess Hospital has planned for new facilities, and now, only two years lie between the Hospital as it stands today and the Deaconess Hospital of tomorrow. In 1995, Deaconess patients and staff

will enter the new \$130 million, 330,000-square-foot Clinical Center at the corner of Joslin Park and Brookline Avenue. With state-of-the-art operating rooms, new imaging suites, sophisticated intensive care units and an expanded Emergency Room, the physical facility will match the high quality of personal care already provided by Deaconess physicians, nurses, technical and support staff. "The focus" of the new building program, according to Deaconess Hospital President and Chief Executive Officer J. Richard Gaintner, M.D., "is on a qualitative advance in patient care."

The Deaconess is simultaneously addressing the need for research facilities with plans for a \$50 million building dedicated to the Hospital's ambitious scientific program. These new laboratories will provide consolidated, technologically advanced space for Hospital investigators to continue their years of research into an artificial pancreas for patients with diabetes, peripheral vascular surgery, new cancer treatments, therapies for HIV-related disease, and many experimental programs that give life and health to seriously ill people.

Construction of the clinical building is already under way, the pylons rising from the ground where Harris Hall had stood since 1913. The building's designers worked closely with all clinical personnel to fashion an environment that enhances the delivery of care for every patient. Corridors, nursing units, and treatment rooms have all been drawn with the thought of focusing attention on patients' needs.

The new clinical complex has been positioned on Brookline Avenue, bringing the Hospital physically closer to its collaborator institutions: the Joslin Diabetes Center, the Dana-Farber Cancer Institute, Harvard Medical School and all the Longwood Medical Area's health care institutions. Meanwhile, all the clinical building's central entrances, waiting rooms and lounges will face a re-landscaped Joslin Park.



Spring
Research facility construction documents complete

Summer
Joslin Park redesign complete

Summer
Clinical Center opens
MRI area converted to a park on the Riverway
Maintenance/Engineering building demolished

1994

Autumn
Brookline Ave./Francis St. park complete
Clinical Center interior work complete

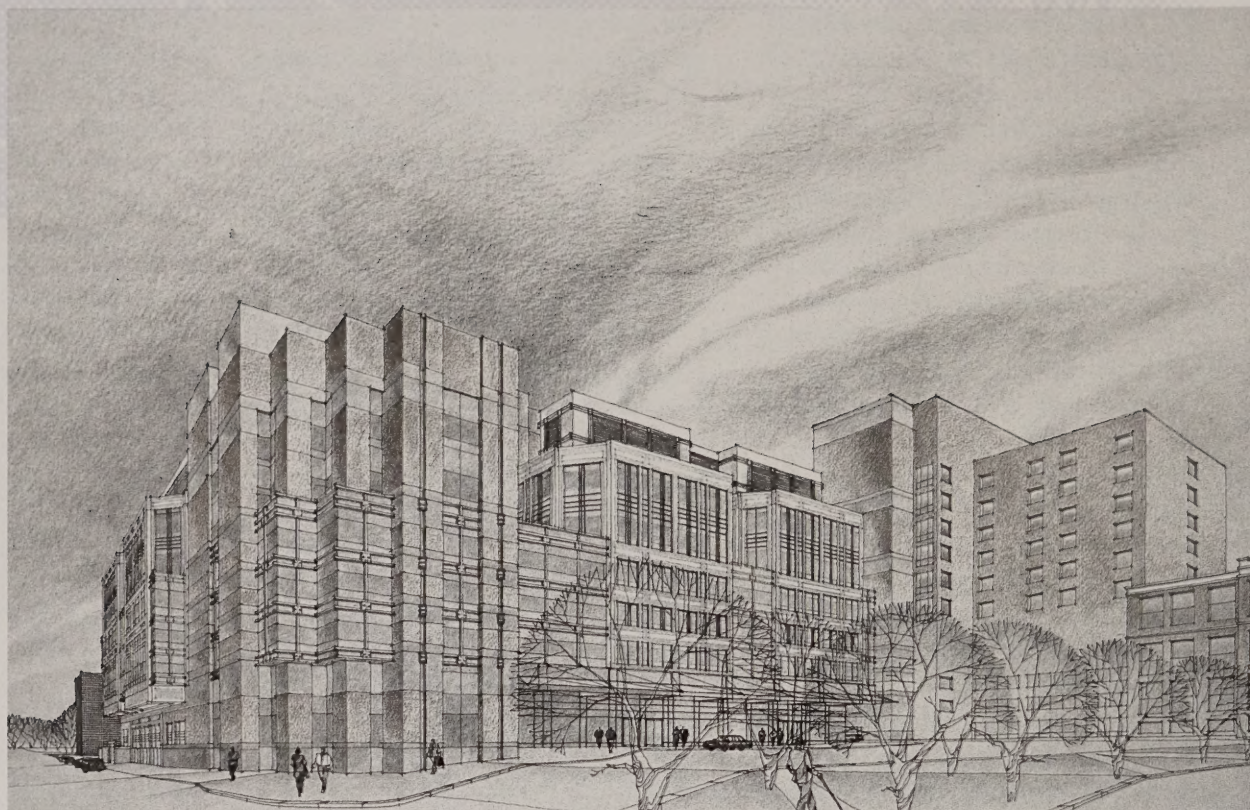
Winter
Clinical Center occupancy begins
Farr Elevator expansion complete

1995

Winter
Farr Building renovations begin

1996

Winter
Research facility construction underway



To support the redevelopment program, The Deaconess Campaign was launched in January 1992. A \$35 million, five-year fund-raising drive, this Campaign is the most ambitious in the Hospital's history.

Having just completed the first full year of this effort, the Hospital has already received over \$14 million in gifts and pledges toward the overall \$35 million need. What is truly remarkable is the breadth of support for the Hospital; contributions have come from a wide variety of donors. Although many contributions have been made by concerned patients and their families (such as Mr. Slaughter), the Deaconess family has stepped forward in an exemplary fashion — almost \$5 million has already come from the Hospital's medical practice groups; trustees, corporators and past supporters have also contributed significantly; and organizers of the employee campaign have planned numerous fund-raising activities for the coming year.

Many of the patient rooms, public areas, and intensive care and diagnostic suites will bear the names of donors who have already come forward to give much needed support to the Deaconess' building program. To educate potential donors about the Hospital's need for modern facilities and adequate space, a comprehensive series of educational programs has been launched. Special initiatives are being undertaken to bring the Deaconess story to the corporate and foundation community as well.

Much more needs to be done to make the Campaign a success. More beneficiaries of Deaconess care will need to come forward, as Mr. Slaughter did, and show their appreciation for the Deaconess Hospital's unswerving devotion to its mission to provide the highest quality care to the sickest patients. For more information about how to help the Deaconess in its battle against disease, please call or write:

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Boston, Massachusetts 02215
(617) 632-8030

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